Seminole Nation Diabetes Program

Feke Yekce Basketball Camp Participant
Registration Form

Name: _____
First **Middle** **Last**

Gender: _____**Male** _____**Female** **Shirt Size:** _____ **Date of Birth:** _____

Mailing Address: _____

Home Telephone: _____ **Cell Phone:** _____

Email Address: _____

Parent/Guardian Name(s): _____

Mother's Work Phone: _____

Phone: _____

Father's Work Phone: _____

Phone: _____

Guardian's Work Phone: _____

EMERGENCY NUMBER (MUST BE VALID WORKING NUMBER): _____

Special Needs: Please indicate any special needs or disabilities that we should know about. Include any medications needed or other necessary information with this form. We will contact you with any questions.

_____
_____
_____

Special Dietary Needs: Please indicate any special dietary restrictions such as vegetarian or food allergies.

_____
_____
_____

Parent Permission Slip and Liability Waiver

I hereby allow my son/daughter/ward _____, for whom I am the legal guardian, to participate in the Seminole Nation of Oklahoma "*Basketball Camp*".

Release: I hereby agree my youth may participate in the above stated Basketball Camp. I further agree to waive and release any claims I might have on behalf of myself or my youth for personal injury, property damage, property loss or death. I discharge and release the Seminole Nation of Oklahoma Diabetes Program, program staff, and program volunteers from any liability, which might exist because of my child's participation in this event. I have read this Release and understand its terms. I hereby sign this Release voluntarily and with full knowledge of its significance.

Signature: _____ Date: _____

All students must have this completed form if they are to participate in this Basketball program. Thank you for your understanding and cooperation.

(Please Check the Appropriate Grade at Time of Registration)

( ) 9th **( ) 10th**

( ) 11th **( ) 12th**

Youth Emergency Medical Information & Waiver

This form must be completed for each youth participant.

This information is kept confidential and will be used only in case of emergency.

Name: _____ **Date of Birth:** _____

Medical History:

Please answer the following questions: YES or NO

Does the participant currently have any physical complaints or chronic illness? _____
If yes, please list: _____
_____

Is the participant currently taking medications of any kind? _____
If yes, list medication and frequency of dosage: _____
_____
_____

Does the youth administer the medication on his/her own? Yes No

Is the participant current with his/her tetanus immunizations? _____
Date of last tetanus immunization: _____

Has the participant had any significant past injuries, illnesses, or surgeries? _____
If yes, please list what and when: _____
_____
_____

Does the participant suffer from allergies of any kind? _____
If yes, please list allergies and reactions: _____
_____
_____

Additional Information: Please use this space to describe any additional relevant medical information not covered by the questions above. _____
_____
_____

Insurance Information:

Is the participant currently covered by medical insurance? Yes No

If yes, please list the name of the insurance provider: _____

Policy or Group # _____ Name of Primary Insured: _____Name of Physician: _____ Phone:_____

Medical Waiver:

In the event of an emergency, I grant permission to Seminole Nation of Oklahoma program staff or program volunteers to transport my child/ward to a hospital/after hour's clinic for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. As the parent/legal guardian, I give full authorization to the Seminole Nation of Oklahoma program staff or program volunteers to secure medical care or treatment for above named youth. This treatment may include assistance from the nearest physician, medical clinic, hospital, trained nurse or EMT in the event of illness or injury that requires immediate medical attention, as to determined by the program staff. In the event that I cannot be contacted, and an emergency has occurred, I give permission to the treating medical institution and/or medical providers to hospitalize and administer the appropriate treatment deemed medically necessary.

I further agree that Seminole Nation of Oklahoma program staff or program volunteers will not be held responsible for injuries or damages arising from the provision of any such emergency medical treatment. I understand that as a parent/guardian, I will be responsible for the cost of any service of treatment provided. This authorization shall remain effective until Basketball Camp is completes. I have read this document, I understand its contents, and I agree to its terms.

Please list any limits to medical treatment on the back of this signed sheet.

_____ _____

Signature of Parent/Guardian Date

Mail Back to:
Seminole Nation Diabetes Program
P.O. Box 1498
Wewoka, OK 74884